

Recommendations of Mental Health Task Force to Improve the Provision of Mental Health Services in the North Carolina Division of Adult Correction

Summary from Susan Pollitt, DRNC
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On September 30, 2015, the Task Force Report was issued to the Director of the Division of Adult Correction, NCDPS. Recommendations cover a number of areas:

- Intake and Assessment
- Housing, Special Units and Control Status
- Suicide Prevention
- Transportation
- Disciplinary Policy and Hearings for Offenders with Mental Illness
- Restraints
- Behavioral Health Services
- Hiring and Retaining Medical and Mental Health Staff
- Training and Employee Support
- Discharge and Community Transition Planning
- General Policy and Culture

Attachments to the Report:

- Best Practice list created by a Task Force member (Criminology Prof at ECU)
- Massachusetts DOC policy on definition of serious mental illness and out of cell treatment (2 pages)
- Georgia policy on serious mental illness (1 page)
- Maryland DOC – same
- Michigan – same
- Pennsylvania DOC
- Philadelphia Jail description of BH services
- References

1. Intake and Assessment

- Identify valid and reliable diagnostic tool to establish major mental disorders for those who screen positive on initial mental health screen.
- Establish a more frequent schedule for mental health screening and assessment and after a critical event
- Screen for trauma and posttraumatic stress disorder
- MOUs with other state agencies to share info

2. Housing, Special Units and Control Status

- Create therapeutic units to house and treat inmates with mental illness as an alternative to 24/7 segregation at each close custody facility
- Reduce the number of control statuses and refine criteria for the classifications
- Establish out of cell treatment requirements within a week of placement in segregation for inmates with a MH designation
- Eliminate the current policy of denying recreation/exercise to all offenders during the first 15 days of segregated confinement so that everyone is afforded recreation/exercise every day after placement in segregation
- Limit segregation of inmates under 21 years of age to no more than 24 hours without the permission of the Director of Prisons or his designee
- Provide every inmate with a mental health designation in segregation for more than 15 days with 10 hours of out of cell structured therapeutic activity in addition to the five hours of unstructured time they receive for recreation/exercise and showers per week.
- Ultimate goal is 20 hours out of cell each week with 10 of those hours devoted to structured activities.
- Open the Robin Unit at the N.C. Correctional Institute for Women to provide more continuity of care for offenders with mental illness who are currently cycling between mental health units and segregated confinement. Study the possibility of opening a similar unit at Central Prison (where men are housed).
- Cease releasing offenders directly from segregation to the community without therapeutic intervention. The type and intensity of the intervention curriculum will be determined by the mental health treatment team.
- Develop criteria to limit length of stay in administrative segregation of offenders with mental illness. (How long may an offender with mental illness stay in administrative segregation status? Consensus is that anything beyond 31 days is considered long-term segregation.)

3. Suicide Prevention

- Adopt a suicide prevention policy
- Train all staff on suicide prevention during the academy as well as refresher training
- Provide training to correctional workers on how to recognize co-worker need for help.
- Every facility should have a suicide watch cell

4. Transportation

- Place cameras in transport vehicles
- Create and use an in-transit medical form
- Through MOUs, require jails to complete the in-transit medical form upon transfer to the state facility
- Through MOUs, all medication lists from the jail offender should be sent to DAC with the offender
- Train transport officers on medical and psychiatric emergencies. At least one transport officer transporting an offender with mental illness should have advanced mental health and crisis training
- Transport of an offender to a medical facility should be a joint decision of custody and medical. Medical staff shall be consulted on the type of transport to be provided.

5. Disciplinary Policy and Hearings for Offenders with Mental Illness

- Require disciplinary hearing officers to consult with a licensed and privileged mental health professional to make a determination if a mental health offender charged with an offense understands and can cooperate in the disciplinary hearing process and whether the inmate should because of mental health reasons be held not responsible for their behavior.

- Under no circumstances should an inmate with a mental illness be held in prehearing segregation for more than 14 days. For M4, M5 inmates this determination should be made within a day of the hearing officer making the inquiry. For M3 offenders, the determination should take no more than 7 days after making an inquiry.
- Provide inmates with mental illness with a properly trained mental health advocate to assist them in the disciplinary hearing.
- Train hearing officers and staff representatives on how mental health can be a mitigating factor in the hearing process

6. Restraints

- Restraints should never be used as punishment.
- If restraints are used on an offender with mental illness – M2 – M5 – the placement should be reviewed by medical staff or custody staff who have received advanced mental health training.
- An in-person assessment of any offender placed in restraints should occur every four hours at a minimum.
- If an offender with mental illness is placed in restraints the review should be conducted by staff who have received advanced mental health training. If medical staff are present, the assessment is to be conducted by medical and custody staff. If medical personnel are not available, two custody staff shall complete the in-person assessment. The offender is to be given the opportunity to toilet, hydrate and a determination made if restraints are needed to continue to control the inmate's behavior. Vital signs are to be taken if medical personnel are present. Regardless of medical person, vital signs are to be taken every 8 hours or more frequently if medically indicated.
- The facility head or designee must be notified immediately when an inmate with mental illness is placed in restraints. The regional director must be notified in writing if the offender is restrained for more than 8 hours. The Deputy Director must be notified if the inmate is restrained for more than 24 hours.
- Develop a crisis protocol to deal with offenders who are non-responsive or noncompliant with requests to stay hydrated.
- Combine policies regarding restraint use into one policy to reduce confusion and error

7. Behavioral Health Services

- There should be daily multi-disciplinary meetings in any institution having medical or mental health staff.
- Trauma informed care should be provided, especially to women prisoners; institutional environments should minimize retraumatization and staff should be trained on trauma informed care.
- Ensure that appropriate multi-disciplinary staffing is accomplished prior to opening transitional care units and that a treatment curriculum is developed which measures activities such that staffing and curricula across units are standardized and consistent.
- Consider creation of specialized case managers to coordinate care and services for M2-M5 offenders.
- Establish strict guidelines for the use of medical and mental health beds as "security beds."
- Eliminate the distinction between inpatient and outpatient mental health departments at the "medical centers" (NCCIW, CP, others?)
- Integrate care under one organizational structure at all institutions and assign one physician to be responsible for overseeing all health and mental health services at each institution.
- Fund electronic medical records (HERO) add 2 positions devoted to HERO data management and analysis, communication, monitoring and reporting.
- Seek legislative permission to participate in a 340B Drug Discount Program – a federal prescription drug program.

8. Hiring and Retaining Medical and Mental Health Staff

- Establish a medical recruiter position.
- Develop special hiring and retention management and human resources policies specific to medical and mental health staff.
- Level state government salaries regardless of Department.
- Request an exemption from the state policy that temporary employees must take a 31-day hiatus.
- Conduct a personnel classification review every 5 years.
- Change hiring for medical positions so a person can remain on the list of candidates for 180 days.
- Consider advertising for positions in the American Psychiatric Association Journal, the American Psychological Association journal, their state journals, and/or other professional journals. These advertisements should be maintained in the journals continuously.

9. Training and Employee Support

- Meaningful training to all staff at the academy on mental illness and special offender issues.
- Develop a training for institutional leadership on how to supervise medical and mental health departments and staff.
- CIT and then on-going training and support for officers in close custody facilities.
- A continuous quality improvement plan or process should be applied to the implementation of CIT.
- Develop a strategic plan for training and retraining of all CIT officers.
- Develop training for mental health and medical staff on how to provide care in a correctional environment
- “For facilities not having CIT trained staff,” create a mental health first responded staff who will be the ‘to-to’ staff when questions about MH or a MH crisis arise.
- Critical incident debriefing should be made a priority.
- Create mandatory criteria for shift reports relate to offenders with mental illness.
- Include employee assistance program refresher at annual training.
- Add questions to the interview process for correctional officers about attitudes of working with offenders with mental illness.
- Include questions about management of offenders with mental illness for management or supervisory positions.
- All DAC personnel access to computers and email accounts.
- Use secure video conferencing to allow community providers, probation officers, to establish relationships with offenders prior to release.
- Wellness checks should be included in employee support plans and they should include assessments and discussions of trauma.
- Create a program to help medical and mental health staff attend courses needed to maintain licensure – capped at \$500/year.

10. Discharge and Community Transition Planning

- Improve the mutual understanding of and collaboration between the LME/MCO and prison social work staff.
- Educate LME/MCO staff about the discharge from prison process and the needs of inmates returning to the community.
- Specialized LME/MCO staff might help.
- Educate prison social workers about changing community MH systems.
- Cross training prison and LME/MCO staff on assessment and treatment planning may help make a more seamless continuation of care.

- Develop a release checklist that can be standardized across facilities and communities and ensure services are aligned with critical times such as 2 weeks before release, 1st day of release, first week of release.
- Coordinate care actors: mental health, substance abuse, physical health, domestic issues, and address training and staffing needs for discharge planners and case managers.
- SOAR train DPS social workers and apply for benefits prior to inmate release.
- Develop a MOU for release of info to LME/MCOs.
- LME/MCO should designate a prison reentry specialist.
- Research numbers of offenders with co-occurring disabilities/needs and partner with LME/MCOs who are providing care coordination so in-prison health histories are considered.
- Prison and probation should communicate prior to release about treatment needs and experiences.
- Housing providers should be incentivized to house offenders with mental illness. DAC establish contracts with vendors to establish transitional care facilities for sex offenders and offenders with MI in 10 locations.
- Pilot Critical Time Intervention for offenders with severe mental illness returning to communities.
- DAC should work more closely with Vocational Rehabilitation.
- Create standardized prerelease programs unique to offenders with mental illness. The program should be pre and post release.
- Aim to provide offenders with mental illness job training in prison.
- LME/MCOs should learn more about evidence-based practices in supporting justice involved persons with mental illness in the community.
- Expand the mental health specialty probation program.
- AOC should explore ways to divert low level offenders prior to incarceration; expand mental health courts and collect outcome data.
- DAC should meet with NC Government Data Analytics Center to develop performance indicators for treatment and housing of mentally ill offenders.

11. General Policy and Culture

- Issue a state wide policy requiring collaboration between medical and custody. Assess facility heads on how well the disciplines work together.
- Daily custody and medical meetings.
- Use a treatment team approach when dealing with difficult offenders with medical or mental illness.
- Nursing, custody, physicians and program managers should round weekly in medical/mental health facilities.
- Review the supervision on medical staff by non-medical administrators.
- Consolidate risk management activities in a separate department in the central office that reports directly to the Deputy Director for Health Services.
- Employ persons to conduct analysis and develop reports to leadership on persistent issues with medical and mental health care.
- Seek accreditation of institutions with major health care missions.
- Consolidate all risk management activities for health services under one umbrella.